PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM

ANNUAL PROGRAM PERFORMANCE REPORT (PPR)

FISCAL YEAR: 2003

STATE: Virginia

NAME OF P&A SYSTEM: Virginia Office for Protection and Advocacy

REPORT PREPARED BY: (Advisory Council Chair) Mark Lester, Chair

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DATE SUBMITTED: _____

_____

[Advisory Council Chair Signature]

SECTION A. POSITION OF ADVISORY COUNCIL AS OF SEPTEMBER 30, OF THIS YEAR

1. Status: Total Number of Persons on Advisory Council.
[In column 1 (Primary ID)/ please indicate the one primary identification of each advisory council member. In column 2 (Total Number), please include all individuals in each category, even those who are listed also in other categories.]

	Primary ID	Total #
a. Number of Advisory Council Members Serving on 9/30	12	12
b. Recipients/Former Recipients (R/FR) of mental health services	4	4
c. Parents/Family Members of R/FR of mental health services	3	3
d. Mental health service providers	NA	0
e. Mental health professionals	NA	2
f. Attorneys	NA	2
g. Individuals from the public who are knowledgeable about mental illness	NA	1
h. Others (please identify). _____	NA	0
i. Vacancies (please identify). _____	NA	0
j. **Total number of members on the Advisory Council (Add items a. and h. for total)	12	12

** This total represents all seats on the Advisory Board.

2. Ethnicity, Race and Gender Composition: See Glossary for definition of "Race/Ethnicity".

Ethnicity/Race	Number of Members
American Indian or Alaskan Native	
Asian	
Black or African American	1
Hispanic or Latino	
Native Hawaiian or Other Pacific Islander	
White	11
Information Not Available	
TOTAL	**12**

Gender	
Male: 7	**Female: 5**
TOTAL: 12	

3.

Does the P&A system have a multi-member governing board?	
Yes **X** If YES, please answer questions below:	No __
a. Total number of governing board members	Total **11**
b. Is the Chair of the PAIMI Advisory Council a member?	
Yes __	No **X** (If No, provide explanation): The PAIMI Advisory Council Chair is an ex-officio, non-voting member of the Board of Directors. The Chair is routinely invited to the Board meetings and a PAIMI Council Chair report is also, routinely included on the Board agenda.
c. Do any other PAIMI advisory council members also hold seats on the Governing Board?	
Yes ____ (How many) ____	No **X**

B. ADVISORY COUNCIL MEETINGS: Provide the information requested in the table below.

	Advisory Council
Number of Advisory Council Members Serving on 9/30	12
Term of Appointment (Number of years)	4
Number of Terms a Member Can Serve	1
Frequency of Meetings	Quarterly
Number of Meetings Held in the Fiscal Year	4
% (Average) of Members Present at Meetings	51%

1. Do PAIMI staff usually attend Council meetings?	
Yes **X**	No ___

If YES, please identify positions of staff usually in attendance: PAIMI staff include a Managing Attorney and three Staff Attorneys. At least one of these positions was at every Council meeting.

2 Do any governing board members usually attend?	
Yes **X**	No ___

The Board Chair routinely attends the Advisory Council meetings. She encourages other Board members to attend as schedules permit.

1. Did the Council work jointly with the governing authority or board to develop the annual PAIMI priorities?	
Yes **X** (Briefly describe process): Several Board meetings were attended by a Council representative. The Chair of the Governing Board has been to all Council meetings. Input has been requested and received by the Governing Board. Open communication has been established between Council and Board. Council is given explanations of the recommendations from the Board and Council has given input into work on by-laws. When agency policies and priorities have or may affect the consumers in the community, Council has been active in receiving and communicating public opinion.	No __ (Provide explanation):
2. Does the Council generally work jointly with the governing authority or board in developing PAIMI policies?	
Yes **X** (Briefing describe process): In similar ways as described in C.1.	No __
3. Did Council members attend any in-state training or educational presentations related to PAIMI activities?	
Yes __ (Briefing describe process): In similar ways as described in C.1.	No **X**

If YES, please describe the activity, the number of council members attending, and reimbursement method to council members in the table below.

1. Did Council members attend any out-of-state training or educational presentations (workshops, conferences, or meetings) related to PAIMI activities?	
Yes __	No **X**

If YES, please describe the activity, number of council members attending, and reimbursement method to council members in the table below.

2. In addition to attending council meetings, council members may engage in other optional activities sponsored or endorsed by the PAIMI system. Please describe any such activities under the proper headings below:

1. Work on governing board or advisory council committees (please identify):

   Chair of Council attended Governing Board meetings.

2. Training or educational presentations to constituency groups or the general public (please identify):

   Two Council members have presented several presentations during the past year on mental health awareness. Another Council member has identified community agencies within the service area that could benefit from additional training for individuals whom work with individuals with mental illness.

3. Systemic or legislative advocacy activities (please identify): N/A

4. Special projects (e.g., institutional monitoring): N/A

5. Other (e.g., fund raising, public relations, etc.): N/A

D. ADVISORY COUNCIL ASSESSMENT OF PAIMI OPERATIONS

List PAIMI program priorities and objectives toward which this fiscal year's activities were targeted below. For each priority, indicate the implementation status using the scale provided and briefly describe the implementation status or extent of progress. For each priority also provide an example of an individual or systemic case and, if applicable, legislative activities. Specifically identify the participation of PAIMI in State mental health planning activities. Examples should illustrate the impact and/or disposition of efforts. See Glossary for definitions. For each priority, provide the following information:

Provide the following information and complete this form for each priority identified for the fiscal year.
1. Priority # P/1/Abuse and Neglect in State-Operated and Community-Based Facilities
2. For each indicator of success, provide the following information: a. Priority # P/1**/ Indicator # 1 – To represent the interests of individuals who are subjected to abuse or neglect as defined in the Priority.** b. Indicator was: /X/Met /__/Partially Met/Continuing /__/Not Met
If "Not Met" was checked, explain:
If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed. VOPA investigated the neglect of SH, a man with Bipolar Disorder, who complained to VOPA that he suffered neglect by the Danville-Pittsylvania Community Services Board (DPCSB), the local public mental health service provider in his area. SH alleged that DPCSB incorrectly found that he did not have Bipolar Disorder, improperly withdrew his antipsychotic medication, and did not adequately supervise its doctors. VOPA did a comprehensive investigation including the review of over one thousand pages of records, interviews with a dozen witnesses, and the receipt and review of two expert reports. After reviewing the entire matter, VOPA concluded that DPCSB had neglected SH. VOPA provided a draft report of its findings to DPCSB giving the opportunity to comment on the report. Rather than comment, DPCSB sued VOPA in an attempt to prevent the report from being made public. VOPA contested the suit, leading to DPCSB dismissing its own Complaint. The report was published. As of the present date, SH is living in the community and being served, successfully, by a different Community Services Board. As a result of the report, DPCSB has made changes in the way it treats its clients and the way it supervises its doctors. S, a male patient at a state operated mental health institution, asked for VOPA assistance when a nurse employed at the institution cursed and insulted him in the presence of at least one other patient. The male patient expressed feelings of humiliation, degradation and embarrassment because of the incident. S told VOPA staff he wanted the nurse to improve her attitude and her treatment of patients, but he did not want her fired. The VOPA staff investigated the incident and worked with the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) and institution representatives to resolve the patient's complaint. The matter was handled through the employee discipline process, and a written notice alleging a Standards of Conduct violation was issued against the nurse. The Standards of Conduct violation was upheld through the nurse's appeal. Since that time, S and several other patients have regularly reported the nurse's conduct to the VOPA staff. Based on these reports, it appears that the nurse's attitude and conduct have taken a dramatic turn for the better, and there have been no more rude or abusive incidents. The male patient has expressed complete satisfaction with the services VOPA provided him in this matter.

L, a male patient of a state mental health institution, approached VOPA staff during a rights clinic being conducted by VOPA staff at the institution. Displaying large open sores covering large areas of both of his feet, he asked the VOPA staff to help him obtain treatment for the sores. L explained that he had developed the sores by walking a long distance in ill-fitting shoes before being involuntarily committed and brought to the institution, but that the sores had not been treated since he arrived. The VOPA staff immediately confronted the charge nurse for L's unit. The nurse apologized, promised to have L's feet treated without delay, and in fact did so within 10 minutes. Although L expressed gratitude to the VOPA staff for helping him obtain medical treatment, L was not willing to sign a records and information release or proceed with a neglect investigation.

The family of TT, a young man with severe depressive and anxiety disorders, requested VOPA's assistance when TT was incarcerated and the jail personnel refused to provide him with his medication. The VOPA staff informed the jail administrators that their actions appeared to be in violation of a number of state and federal laws and regulations. When this failed to obtain the medication, VOPA staff required the Jail Administration to bring TT to a nearby mental health clinic for an emergency mental health evaluation. VOPA staff arranged for the psychiatrist who had originally prescribed TT's medication to conduct the evaluation, and she promptly ordered the jail to dispense TT's medications as prescribed. Once TT was back on his medications, his condition began improving right away. A few days later, however, a family member called VOPA to report that, although the jail staff were dispensing TT's scheduled medications as prescribed, they had told him that he would be put into segregation if he asked for his "prn" (medication prescribed on as "as needed" basis). VOPA promptly intervened. The jail rescinded the condition, and TT received his prn medication without fear of being placed into segregation.

1. Priority # P/1/Abuse and Neglect in State-Operated and Community-Based Facilities

2. For each indicator of success, provide the following information:

a. Priority # P/1**/ Indicator # 2 - To increase the awareness of facility patients, their families, and facility staff of VOPA services and legal rights through outreach, technical assistance, and training activities.**

b. Indicator was: /**X**/Met /__/Partially Met/Continuing /__/Not Met

If "Not Met" was checked, explain:

If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

1. VOPA staff routinely provide outreach at all state-operated mental health institutions.

2. VOPA staff routinely attend Local Human Rights Committee* (LHRC) meetings at selected providers.

*A group of volunteers from a designated locality who meet regularly to review provider policies that affect consumers, conduct fact-finding hearings in cases where a consumer has alleged a violation of his/her rights, and conduct reviews of capacity as it relates to ECT and appointment of legally authorized representatives. The group consists of consumers, family members of consumers, professionals, and other interested individuals. They are the quasi-judicial enforcement entity for the DMHMRSAS Human Rights regulations.

3. VOPA staff were presenters at two continuing education courses attended by more than 350 mental health professionals from a variety of mental health settings including community services boards, state mental health institutions, general hospitals, and private clinics. The seminar, entitled "Virginia Mental Health and the Law," was a continuing education course approved by the Association of Social Work Boards, American Psychological Association, National Board for Certified Counselors, American Nurses Credentialing Centers Commission on Accreditation, American Health Information Management Association and Commission for Case Management Certification.

4. VOPA staff provided training to 16 staff at a day program for individuals with disabilities. The training consisted of general information about VOPA and the newly enacted Department of Mental Health, Mental Retardation, and Substance Abuse Services' Human Rights Regulations.

5. VOPA staff provided an overview of VOPA services and participated in a panel discussion entitled "A Move Toward Community-Based Services" sponsored by the civic organization Prince William County Committee of 100.

6. VOPA staff presented a general overview of VOPA services to members of a state mental health institution's Advisory Council.

7. VOPA staff conducted 123 impromptu on-unit/location patient outreach activities at state mental health institutions. It should be noted that some of these are on the wards of the institutions, while others are conducted in day rooms, conference rooms, etc. They may or may not be coordinated with/by the institution representatives.

8. VOPA staff distributed over 8900 copies of VOPA publications to institutions pursuant to negotiated agreements for them to use the publications in employee training and/or patient group therapy sessions, to distribute the publications to patients (upon admission), staff, guardians and legally authorized representatives, and/or to maintain displays of the publications in lobbies and other public places.

9. VOPA staff conducted 30 on-location outreach visits to community programs and facilities.

10. VOPA staff distributed over 1500 copies of VOPA publications/posters/promotional items to Community Services Boards, community programs and facilities, and other community-based programs which established displays or distribution agreements, and did not previously display or use VOPA materials.

11. VOPA staff conducted eight (8) outreach activities with consumer/family organizations including National Alliance for the Mentally Ill affiliates, the Mental Health Association, and "clubhouses" (psychosocial rehabilitation providers).

12. VOPA staff distributed over 400 pieces of VOPA literature to consumer/family organizations.

13. VOPA staff organized and conducted a mass mailing of VOPA literature and posters to community facilities in Southside Virginia, planned a follow-up visit program to assure that the mailed materials were properly posted/displayed, and made unannounced visits to 21 community facilities. All of these facilities when visited were either in compliance or were brought into compliance at that time.

1. Priority # P/2/Community-Based Services in the Most Integrated Setting

2. For each indicator of success, provide the following information:

a. Priority # P/1**/ Indicator # 1 – To ensure that adults and juvenile ready for discharge from public or private residential facilities are discharged to the community with appropriate services and supports.**

b. Indicator was: /**X**/Met /__/Partially Met/Continuing /__/Not Met

If "Not Met" was checked, explain:

If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

VOPA represents LC, an individual with mental illness who had been found Not Guilty By Reason of Insanity (NGRI) of a misdemeanor. LC was sent to a state mental health institution and spent nine years there. In the interim, Virginia passed a law stating that people found NGRI of misdemeanors could spend no more than one year in forensic custody. VOPA learned of LC through the National Alliance for the Mentally Ill. VOPA contacted LC, who requested VOPA's advocacy services. VOPA filed a motion for LC's release, pursuant to a discharge plan developed by Department of Mental Health, Mental Retardation, and Substance Abuse Services. The Commonwealth Attorney of the City of Norfolk opposed the discharge. After legal argument, the Court held that LC should be discharged. He is currently living successfully in the community.

VOPA helped BB, a young male patient of a state mental health institution, to have his wishes respected in the discharge planning process. BB asked VOPA for assistance after BB's case manager (an employee of the local community services board responsible for discharge planning with patients) refused to plan for BB to return to his pre-hospitalization placement after discharge. VOPA confirmed that the placement BB requested was clinically appropriate to his needs. VOPA then addressed the problem by educating and supporting BB's treatment team's effort to pursue respectful discharge planning. VOPA negotiated an informal case specific monitoring agreement, about BB's discharge plan and any changes to it, with an administrator of the institution. BB was subsequently discharged to his desired placement and is currently

living successfully in the community.

A patient of a state mental health institution told VOPA she had required frequent hospitalizations because of her inability to obtain adequate post-discharge case management services. VOPA determined that the community services board's (CSB) refusal to provide cases management services to this patient was based on their rigid interpretation of CSB eligibility guidelines. VOPA worked with the CSB to have the patient reassessed and her eligibility for case management services re-examined. When this process was completed, the patient was approved for the desired services and a case manager was assigned. At last report, the patient was living successfully in the community.

1. Priority # P/2/Community-Based Services in the Most Integrated Setting

2. For each indicator of success, provide the following information:
   a. Priority # P/2/ **Indicator # 2 – To ensure that adults and juveniles who have been discharged from an inpatient psychiatric setting to the community, who are at risk of reinstitutionalization, have access to appropriate services and supports in the most integrated setting.**
   b. Indicator was: /**X**/Met /__/Partially Met/Continuing /__/Not Met

If "Not Met" was checked, explain:

If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

A male patient (FW) was discharged from a state mental health institution pursuant to a rather complex discharge plan, which was designed to help him avoid frequent re-hospitalizations. One of the supports provided in the plan required FW to travel some distance each day to attend an appropriate day treatment program. Soon after FW was discharged, it was discovered that no funding had been arranged to provide the necessary transportation between his residential placement and the day treatment program (in an adjacent county). The local Department of Social Services (DSS) told relatives it would take 45 days to process a funding application, and refused to expedite the application despite the circumstances. Frustrated, a relative contacted VOPA for assistance. VOPA took the matter up with the local DSS eligibility department, and ultimately with its director. The funding application was subsequently expedited, and FW began receiving transportation services about one week after VOPA became involved. At last report, FW was living successfully in the community.

This case arose when a state mental health institution appointed an out-of-state parent as an adult patient's legally authorized representative (LAR) after HQ and the in-state parent refused to go along with the institution's treatment and placement recommendations. As the LAR, the out-of-state parent approved recommended medications and congregate residential placement, and prevented the in-state parent from obtaining records or information concerning HQ's treatment and discharge plans. HQ was discharged to a congregate residential placement, which he promptly left, to return to live in his home with the support and assistance of the in-state parent, who lived nearby. HQ asked VOPA for advice to ensure that the in-state parent would be responsible for his treatment and placement decisions during periods of incapacity. VOPA discussed the client's needs and wishes and then advised him regarding his rights. Based on this discussion, an appropriate Advance Medical Directive/Durable Power of Attorney was developed to prevent future abuses of his right to self-determination.

1. Priority # P/2/Community-Based Services in the Most Integrated Setting

2. For each indicator of success, provide the following information:
   a. Priority # P/2/ **Indicator # 3 – To participate in and contribute legal expertise and consultation to the state Olmstead Task Force for the purpose of facilitating the creation of an appropriate and comprehensive "Olmstead Plan" to ensure that persons with mental illness receive appropriate supports and services in the most integrated setting.**
   b. Indicator was: /**X**/Met /__/Partially Met/Continuing /__/Not Met

If "Not Met" was checked, explain:

If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

The Olmstead Task Force completed its year-long work by releasing a comprehensive Report recommending that the Commonwealth take concrete and bold steps to ensure that people with disabilities are empowered to live in the most integrated setting. VOPA served in a leadership capacity on the Task Force, serving as agency convener to two (out of the seven) issue teams, serving as liaison to a third team, and serving on the twenty-member steering committee. VOPA also offered several amendments to the draft final plan, most of which were accepted, resulting in a more streamlined, more effective plan.

1. Priority # P/3/Deaths and Critical Incidents in State Mental Health Facilities and Community-Based Facilities

2. For each indicator of success, provide the following information:
   a. Priority # P/3/ **Indicator # 1 – To ensure that incidents of abuse and neglect are properly reported and investigated and that facilities take appropriate remedial action in instances of abuse or neglect.**

   b. Indicator was: /**X**/Met /__/Partially Met /**X**/Continuing /__/Not Met

If "Not Met" was checked, explain:

If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

Noted below are examples of VOPA work related to CIRs.

A preliminary inquiry was conducted about inappropriate touching, kissing, and other physical contact with a female patient (MN) by a male employee of a state mental health institution. An investigation conducted by the institution substantiated the patient's allegations. The investigation raised issues of whether appropriate safeguards are in place to prevent circumstances where an employee has the opportunity to exploit a patient. The report also raised concerns whether appropriate action was taken when a supervisor noted that the male employee was engaging in inappropriate interaction with the female patient. The institution's investigation report contained recommendations for measures aimed at ensuring that staff do not have opportunities for inappropriate contact with patients. These recommendations were implemented. VOPA determined that the facility took the appropriate action in this case.

A preliminary inquiry was conducted as a result of VOPA receiving a complaint about medication services provided by the Program of Assertive Community Treatment (PACT) team of the local Community Services Board (CSB). The anonymous complaint alleged, among other things, that: medications were not being given on time; appropriate procedures for refused medications were not being followed; medication errors were not being appropriately documented; medications were being taken home by staff/medications were not being properly secured; tests for blood levels of lithium, carbamazepine, valporic acid, clozapine were not routinely being done; and that the negligence of nursing staff contributed toward the death of a client. VOPA conducted an interview of the PACT team supervisor and reviewed a random sample of PACT team client records. DMHMRSAS Licensing conducted an investigation into this complaint. As a result of VOPA's preliminary inquiry, the Community Services Board developed and implemented a corrective action plan. VOPA determined that appropriate corrective action was taken.

The Code of Virginia requires that deaths and certain defined critical incidents in state mental health institutions be reported to VOPA within designated timeframes. Based on the content of the critical incident report (CIR), VOPA may take varying steps. This will always be an on-going effort for VOPA as it is a state required activity. During FY 2003, there were 645 critical incidents reported to VOPA from state mental health institutions. Of those, ten were opened for preliminary inquiry. Eight were closed with no further action required and two were elevated to full investigations.

1. Priority # P/3/Deaths and Critical Incidents in State Mental Health Facilities and Community-Based Facilities

2. For each indicator of success, provide the following information:
   a. Priority # P/3/ **Indicator # 2 – To improve the safety of DMHMRSAS facility residents by determining whether there are patterns or trends contributing to a disproportionate number of critical incidents at DMHMRSAS-operated mental health facilities.**
   b. Indicator was: /**X**/Met /__/Partially Met/Continuing /__/Not Met

If "Not Met" was checked, explain:

If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

The DMHMRSAS met with their facility risk managers to more accurately report critical incidents among facilities. This resulted in an increase in the number of CIRs reported to VOPA during the fiscal year. It was noted, after discussion with DMHMRSAS officials that although there was an increase in CIRs reported, there was more uniformity in reporting. VOPA quarterly analysis of the CIRs did not reflect any patterns or trends that might conclusively lead to the increase.

1. Priority # P/3/Deaths and Critical Incidents in State Mental Health Facilities and Community-Based Facilities

2. For each indicator of success, provide the following information:
   a. Priority # P/3/ **Indicator # 3 – To improve the safety of patients of community-based facilities by beginning to assess extension of the critical incident notification system to community-based facilities through future legislative action.**
   b. Indicator was: /**X**/Met /**X**/Partially Met/Continuing /__/Not Met

If "Not Met" was checked, explain:

If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

VOPA continues to analyze its critical incident reports system and reports (some were also received from some community-based providers) in an attempt to assess whether it would be practical to extend the CIR requirements to community-based providers. The VOPA Board of Directors has established an ad hoc committee to explore the extension of the reporting system to include requiring community-based providers.

VOPA enforced reporting requirements by Psychiatric Residential Treatment Facilities (PRTFs) and received several reports of patient injuries.

1. Priority # P/4/Informed Consent to Treatment

2. For each indicator of success, provide the following information:
   a. Priority # P/4/ **Indicator # 1 – To represent the interests of persons who have been treated in the absence of or contrary to informed personal consent or that of a properly authorized substitute decision-maker.**
   b. Indicator was: /**X**/Met /__/Partially Met/Continuing /__/Not Met

If "Not Met" was checked, explain:

If “Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

VOPA represented a woman who had been admitted, pursuant to a Temporary Detention Order, to a private hospital. The woman complained to VOPA that she was being medicated over her objection. VOPA informed the hospital that it was improperly and illegally forcibly medicating the woman. The hospital originally claimed that it had a right to do so. VOPA then informed the hospital that it would file suit to enjoin it from forcibly medicating the woman. The hospital then agreed not to forcibly medicate her.

A patient of a state mental health institution requested VOPA’s assistance to resolve medication issues including being forced to take medication over her objection and in spite of negative side effects stemming from the use of the medication in question. The patient’s legally authorized representative (LAR) reported to VOPA that the patient’s present psychiatrist, as well as the preceding psychiatrist, had been forcing the patient to take the offending medication for at least six months. The LAR also told VOPA she had joined with the patient in asking the hospital to change the patient’s medication, but that their request had been ignored. VOPA reviewed the patient’s chart, and then advised her and her LAR that they had proper grounds to sue for deprivation of civil and constitutional rights. Despite the patient’s strong legal position, she and her LAR advised VOPA that they were unwilling to sue, except as a last resort. VOPA obtained the following relief in the case: (1) the patient was transferred to another state mental health institution, which was two hours closer to the area where her family lived; (2) the offending medication was discontinued, with no apparent lasting after-effects; (3) the patient and her LAR worked closely with the treatment team at the new institution to develop a treatment plan that incorporated the patient’s preferences; (4) the charts of all institution patients were reviewed to detect and correct any informed consent deficiencies affecting other patients; (5) of the two psychiatrists who wrote orders for the patient to be medicated in the absence of informed consent, one resigned and the other was appropriately disciplined; (6) the institution’s “consent to medication” form and LAR forms* were revised to clearly inform patients and LARs of their treatment-related rights, including the right to refuse a particular treatment; (7) institution procedures were revised to require special measures to ensure that patients/LARs are fully apprised of participation-in-treatment and informed-consent rights before they are asked to give consent for any medication or treatment; (8) the institution agreed to distribute certain VOPA publications to all existing patients and LARs, and to all newly admitted patients and newly appointed LARs as they were admitted or appointed; (9) the institution revised policies and procedures to create a fail-safe system to ensure that future refusals or irregularities of consent to medication will be caught and dealt with appropriately before the consent is relied upon as authority to administer medication to patients; (10) institution policies and procedures were revised to establish a fail-safe system to ensure that physicians discuss contemplated medications and treatments with patients (and LARs as applicable) and satisfy all informed consent requirements before the patient/LAR is asked to sign a consent form; (11) all members of the institution’s Medical, Social Work, and Psychology staff were required to attend in-service training on patient treatment planning and informed consent rights, and on the policy and procedure changes described above; and (12) the director of the institution issued a formal apology to the patient and her LAR.

*LAR forms are used to appoint an alternate decision maker when an individual is found to lack capacity to make his/her own decisions about treatment and information disclosures.

1. Priority # P/5/Special Education Advocacy and Legal Representation

2. For each indicator of success, provide the following information:

a. Priority # P/5/ **Indicator # 1 – To protect the legal rights of and represent the interests of students with mental illness who are receiving special education services and supports in an inappropriate placement.**

b. Indicator was: /**X**/Met /__/Partially Met/Continuing /__/Not Met

If “Not Met” was checked, explain:

If “Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed.

VOPA efforts in this area involved a 16 year-old female student with mental illness who required homebound instruction. Despite her parents persistent efforts at self-advocacy, the school district failed to assign a teacher for two months. When the parents involved VOPA, the school district immediately provided a teacher to instruct the homebound student. The family reports no further problems in obtaining required services from the school district.

Although no case was formally opened here, the student received quality PAIMI services and by all reports, everyone is highly satisfied.

Other PAIMI Activity

VOPA staff participated monthly in the Mental Health Planning Council.

Virginia's Mental Health Planning Council represents consumer, family, and advocacy interests. Public Law 102-321 states explicitly that the Council members' role encompasses active advocacy for a more responsive service system and assistance in the monitoring, implementation and oversight of service system objectives of Virginia's Mental Health Plan. Council members advocate for the continuing development and expansion of a comprehensive community-based service system for Virginia's priority mental health populations -- adults with a serious mental illness, children and adolescents with a serious emotional disturbance, and children at risk of developing a serious emotional disturbance. The Council is especially interested in assuring that mental health consumers in Virginia receive quality care, case management services, and housing services. The Council is committed to assuring that the provision of these services is coordinated among agency providers (Taken from DMHMRSAS website).

VOPA staff also participated in the Adult Services Committee (a committee of the Virginia Mental Health Planning Council). The Adult Services Committee has primary responsibility to identify service priorities including addressing the various criteria in the annual Mental Health Plan. The Committee will become informed regarding the statewide system of publicly funded services for adults with serious mental illness and work with Department staff to develop priorities, goals and objectives, indicators and targets (Taken from DMHMRSAS website).

In addition, VOPA staff participated in the DMHMRSAS Advisory Council for Services to People Who Are Deaf, Hard of Hearing, Late Deafened and Deaf-Blind. Their mission is to provide the DMHMRSAS support, consultation, and technical assistance regarding comprehensive mental health, mental retardation, and substance abuse services for persons who are deaf, hard of hearing, late deafened, or deafblind. Meetings were held quarterly and a VOPA staff served as the elected secretary.

VOPA tracks and monitors relevant legislation each year. This includes commenting on proposed bills and providing research and information to advocates and legislators. This effort includes legislation relevant to PAIMI and individuals with disabilities who may be served by PAIMI.

It is the general and unanimous feeling of the Council that VOPA has been an instrumental part in assisting individuals in our state to assert their human rights. VOPA has grown rapidly over the past year as more individuals and community agencies began to understand the role VOPA plays in maintaining their rights. The Executive Director accepts input openly and willingly from the Council and it is evident that the Council’s input is utilized in setting up the goals and priorities of the agency. The Governing Board has placed the Chairperson of each Advisory Council as non-voting members of their Board in order to receive direct input from the Advisory Councils. VOPA staff appears to approach each case it receives and investigates as an individual case realizing that each case has its own characteristics, then sincerely and diligently investigating the merits of each.

It is also the general opinion of the Council that the VOPA staff has put forth a great amount of effort in setting their goals and priorities for the agency. These goals and priorities reflect the majority of the concerns expressed by individuals in our communities.

We sincerely hope that the relationships that have been established between VOPA staff, the governing Board, and the Councils continue to be an open and beneficial relationship to continually meet the needs of our communities.

E. OTHER COMMENTS CONCERNING PAIMI SYSTEM OPERATIONS: Describe any special initiatives, problem solving techniques, or innovative practices that might be helpful to other P&A Systems.